INTERNATIONAL CONFERENCE ON HEALTH RESEARCH FOR DEVELOPMENT

COUNCIL ON HEALTH RESEARCH FOR DEVELOPMENT

COHRED

8 and 9 March, 1993

Palais des Nations • Geneva • Switzerland

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Countries, Stockholm, Sweden

United Nations Development Programme, New York, U.S.A.

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Preface

A "Green Revolution" in Health catalyzed by research - is it possible?
This question preoccupied the group of health researchers and donors meeting at the Edna McConnell Clark Foundation late in 1986. Many believed that improved technology, produced through an intensive, focused research effort, guided by a central mechanism, could solve the health problems facing the world's poor. Such an international research effort would lead to the cheap, effective and simple health technologies needed by the countries of the South much as the Consultative Group in International Agricultural Research (CGIAR) had contributed to the world's supply of food. Some, however, were skeptical about the preeminent role of technology for improving the health of the poor people of the world. Would the technologies be applied? Would the poor be able to afford them?

Inequities in health in the face of rapidly rising costs of health services were, as yet, not a major political issue. And the first Human Development Report sponsored by UNDP, underscoring growing inequities between the rich and the poor, would not appear until 1990.

The poor, their communities and their organizations received "lip-service" but only rarely did they participate in making the decisions that affected their communities, their families and their lives. The need for explicit choices and the setting of priorities within the health sector in order to achieve equity in health was rarely considered by the health services or the decision makers. The provision of quality health services, accessible to all people, at a cost that a country could afford and the choices this entailed was a challenge for the future.

The emphasis of researchers remained on new and better technologies. These technologies would improve the quality and duration of life. But for what portion of the world's people?

The group meeting at the Clark Foundation were uncertain about a "Green Revolution" for health. Instead of launching a new international research program, they suggested an independent Commission on Health Research to determine the role of research in improving the health and well-being of the poor and to recommend how to bring this about. Following wide consultation the Commission on Health Research for Development was formed and using a broad definition of research, concluded that research was essential to improving human health and that research to support informed decision making was of the highest priority. In other words, research must focus upon both the problems of

today and those we may face tomorrow and information based upon scientific enquiry, should influence decisions about health.

The Commission decided that health research was primarily country specific and that it must be inclusive. Those affected by the problems must be actively involved in the process of finding solutions. This characterization of research became the basis for the strategy of Essential National Health Research (ENHR). A strategy through which a country's researchers, decisions makers and people work in partnership to identify problems, set priorities and search for solutions using the methods of science. Needs and opportunities for international research initiatives emerge from national problems and plans.

While the Commission carried out its work, the world experienced an almost universal decline in the ability of central governments to solve their people's problems. Health and social services received the greatest shock. And the people lost faith in their governing bodies.

Today, in most countries, available health services are providing quality care for a shrinking portion of the people at an ever increasing cost. It appears impossible to provide quality services, accessible to all people, including the poor and those at highest risk, at a price that a country can afford. All countries face this dilemma. Those countries spending US$ 2000 per person, per year on health care are faring no better at this than those who have only US$ 1.00 per person available.

The Commission evolved the strategy of Essential National Health Research as a means to achieve equity in health both within a country and between countries. While the Commission focused upon the plight of poor people of the South, today its recommendations apply throughout the world.

All countries will have to make choices concerning health and health care. Priorities will have to be set. These choices and priorities should be based on sound, scientific information about problems and possible solutions. Research should provide the needed information and thus influence these choices.

The Essential National Health Research Strategy is a way for difficult choices to be made and problems solved using the methods of science. Some countries are already using the Strategy, and many others wish to do so. Most of these countries are poor and require technical and financial assistance to carry out their Essential Health Research. We hope that this assistance will be forthcoming and that the Strategy will be applied widely. The health and well being of most of us depends upon it.

Background and Introduction

The first international conference on Health Research for Development took place in Stockholm, Sweden, in February 1990, to consider the Report of the Commission on Health Research for Development.[1] The Commission had been established in 1987 to recommend how research might improve the health and well-being of the peoples of the developing world.

Following a world-wide analysis of health conditions and health research, the Commission concluded that research is an essential, but often neglected link between human aspiration and action, and that there are many ways in which research should be applied to improve health. Research to support informed and intelligent decision making for health action was of highest priority and good health was a driving force for development based upon equity and social justice.

The focus of health research should be national, and each country no matter how poor, should have a health research base which will enable it to understand its own problems and to enhance the impact of limited resources. The process of setting priorities for national health research must be inclusive and involve scientists, decision makers and representatives of the people as equal partners. The resulting national health research agendas should serve as a starting point for global research efforts. The Commission called this concept Essential National Health Research (ENHR).

The conference participants endorsed the Commission's report and recommended the creation of an interim body, the Task Force on Health Research for Development, with a life not exceeding two years. The Task Force would carry on with the Commission's activities of advocacy and support and bring forward proposals for a long-term arrangement that could mobilize resources for ENHR on a continuing basis. The arrangement should also provide support for international networks aiding the ENHR process and advocate the relevance of health research for development. The Conference turned to two organizations to assist in turning the Commission's recommendations into reality. These were the two organizations with a specifically research remit, IDRC and SAREC.

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[1] Health Research: Essential link to Equity in Development, Oxford University Press, 1990

The Boards of both IDRC and SAREC agreed to the joint management of the Task Force, and the two organizations asked the Edna McConnell Clark Foundation (USA) and the Gesellschaft für Technische Zusammenarbeit (GTZ), Germany to join them. The United Nations Development Programme (UNDP) acted as the host Agency and gave space and facilities to the Task Force Secretariat at UNDP's Geneva offices.

The Task Force on Health Research for Development was formed in late 1990. By March 1993, eighteen countries were implementing the ENHR Strategy, and another eighteen were seriously considering doing so. Each country which adopts the Strategy evolves its own ENHR process and uses different national organizations as the institutional base for the Strategy. These include government Ministries (Health, Science and Technology, Education, etc.), academic institutions and national, non-governmental organizations.

In some countries, the ENHR process was built up from the community using national NGOs, while in others it started centrally with either academic or governmental institutions taking the lead. In all cases, consultations carried out at many different levels, and the free and open debate among community members, researchers, health care providers and decision makers were the keys to success.

In March of 1993, IDRC and SAREC, in association with UNDP, sponsored the Second International Conference on Health Research for Development to consider the work of the Task Force and to decide upon the need for, and the form of, any future international coordinating mechanism for the ENHR Strategy. The second conference was thus an appropriate conclusion for the work of the Task Force on Health Research for Development and a logical follow-up to the recommendations of the first conference in 1990.

The Task Force had promoted and facilitated Essential National Health Research, and many more countries than expected were applying the Strategy. However, only the countries themselves could estimate the value of ENHR for each of them. Only they could recommend the continuation of the facilitation and coordination, and if so, how it should continue. This was their Conference.

This report attempts to express the spirit of the Conference and the crucial role played by the countries of the South. The proceedings have been divided into four sections. The first three put forward the points of view of the Sponsors, two eminent leaders from the South involved with ENHR and the experiences of the countries participating in the Conference. The last section (Moving Ahead Together) presents the debate amongst participants and the outcome of this debate.

Health Research For Development
Essential National Health Research (ENHR)

Second International Conference

Palais des Nations, Geneva, 8 and 9 March 1993

Agenda

	Reference Documents
1. Welcome and Opening of Conference (Mr. T. Rothermel (UNDP), Mr. Keith Bezanson (IDRC) and Mr. A. Wijkman (SAREC))	
2. Chairman's Remarks (Prof. Demisse Habte, Director, ICDDR,B (Bangladesh))	
3. Adoption of the Agenda	INT/CONF(2)/93.1
4. The Commission, the Task Force and the ENHR Strategy 1988-1993 (Prof. V. Ramalingaswami, Chairman, Task Force on Health Research for Development)	INT/CONF(2)/93.2 INT/CONF(2)/93.3 INT/CONF(2)/93.4
5. Keynote Address (Dr. A.R.A. Bengzon, Executive Director, Intercare Research Foundation Inc., (Philippines))	
6. "Choosing the Road to Health" -Audio-visual presentation in the Cinema	Salle XIV
7. Country Experiences with the ENHR Strategy	INT/CONF(2)/93.5, Annex 1 INT/CONF(2)/93.6
8. Facilitating the ENHR Strategy	INT/CONF(2)/93.9

8.1	Future Management of the ENHR Strategy at the Global Level (Introduction by Dr. Rolf Korte, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ))	
8.2	Consideration of the Draft Plan of Work and Budget for the Period 1 January 1993-31 December 1997 (Introduction by Dr. Wilson, Secretariat)	INT/CONF(2)/93.5
8.3	Consideration of a Management Mechanism	INT/CONF(2)/93.5 Annex 2 INT/CONF(2)/93.10
8.4	Financial Support for COHRED for the period 1 January 1993-31 December 1997	INT/CONF(2)/93.7
9.	Presentation of the Interim Board of COHRED(Introduction by Dr. C.-H. Vignes, Consultant to the Conference)	INT/CONF(2)/93.8
10.	Other Business	
11.	Closure of the Conference	

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Summary

The Second International Conference on Health Research for Development culminated the work of the Commission (1987-1990) and the Task Force (1990-1993) on Health Research for Development. The participants considered the work of the Task Force, in particular the promotion and facilitation of the Strategy of Essential National Health Research (ENHR) and were asked to decide if a mechanism to continue this facilitation and coordination of ENHR should be established. And if so, what type of mechanism should it be.

Eighteen countries and groups from countries, presented their experiences with the ENHR process and health research. These experiences and their unanimous opinion that the facilitation of ENHR should continue, convinced the participants to consider the option for continuation prepared by the Task Force. Following extensive debate the participants adopted the Declaration of Health Research for Development which opened the way for the establishment of the Council on Health Research for Development (COHRED).

COHRED was constituted on 10 March 1993 the day following the Conference and registered as a non-governmental organization in Geneva, Switzerland. COHRED is located within the United Nations Development Programme in Geneva. As at 30 November 1993 COHRED was active and thriving.

The Sponsors' Perspective

The representatives of the three Sponsoring Agencies, UNDP, IDRC and SAREC, welcomed the participants to the Conference and presented their views. IDRC and SAREC, the two agencies charged with the creation of the Task Force on Health Research for Development by the Nobel Conference in 1990, contributed close to 50 % of the financial support of the Task Force and UNDP was the host agency for the Task Force.

United Nations Development Programme (UNDP)
Mr. Timothy S. Rothermel, Director for Global and Interregional Programmes

UNDP has followed this endeavor with interest since the agency participated in the meeting at the Edna McConnell Clark Foundation in 1986 to consider how research might improve the health and well-being of the people of the South, and how such research might be brought about. This resulted in the Commission on Health Research for Development. Following the release of the Report of the Commission and the decision to begin the Task Force, UNDP offered the Group a home. This relationship has worked very well and we have been pleased to have the Task Force Secretariat as members of the UNDP family in Geneva.

As predicted by the Commission, the ENHR concept is meeting a real need in countries struggling to provide quality health services, accessible to all (including those at high risk) at a cost that the country can afford. This is an urgent need, not only in the countries of the South, but also in those of the North.

This Conference was planned two and one half years ago, just after the release of the Commission's Report, to consider the work of the Task Force and the future of the ENHR Strategy and during this interval, the Conference has taken on greater importance in view of three developments which have come about following the end of the "Cold War."

The first is the increasing insistence of the world's people to participate more directly in the decisions that affect their lives; such as health care and services. This is happening in all parts of the world. Involvement of the people as true partners in the decision making process is a crucial component of the ENHR Strategy, and this participatory process is very much in keeping with the UNDP policy of providing assistance to the birth of democratic processes in countries. Such assistance has become one of the major activities of UNDP and other agencies of the United Nations System over the past two years.

The second development is the increased emphasis by governments upon the health of all their people and upon the health of our planet. The UNDP sponsored Human Development Report has played an important role in making us aware of the inequities which exist within and between countries and societies. Inequities which continue to increase. However, our wish to help the poor people and our planet will require a shift of resources among and within sectors and societal groupings. The concept of equity will require difficult choices within the health sector. The ENHR Strategy should help countries and their people make such choices in a rational and scientific manner.

The third event is the World Bank's 1993 Development Report on Investments in Health. One of the conclusions of this report is that increased investment in research will have the greatest impact on the health of the world's people over both the short and the longer-term. This presents an opportunity and a challenge to the research community which the ENHR Strategy should help it meet.

At this conference, the participants must decide upon the future of the ENHR Strategy elaborated by the Commission and promoted by the Task Force. The Strategy states that health research is firstly country specific and the responsibility of each country. Thus, ENHR is a national strategy and not an externally imposed program. International health research initiatives evolve from country needs.

Countries, individually and together, must decide upon the value of the strategy and the need for a coordinating mechanism. You may decide to accept the advice of the Task Force and recommend the creation of a new type of management mechanism; an NGO operating within the United Nations System to facilitate the implementation of ENHR. Such a mechanism may prove to be one way in which UN Agencies can become more responsive to their member countries. If you so decide, UNDP would be pleased to continue to participate in this endeavor.

The International Development Research Centre (IDRC, Canada)
Dr. Keith Bezanson, President

IDRC has been most pleased to work with, and to be one of the principle sponsors of, this process called Essential National Health Research. We have also been very pleased, over the last two years, to be one of the principle sponsors of the Task Force, which has carried us to where we are today. All of us are indebted to the members of the Task Force for their achievements in implementing the recommendations of the Commission.

For us, ENHR is basically an experimental approach to a simple process idea. We have been pleased to sponsor that process, that idea, that experiment. There are four main reasons for this.

The first is **timeliness**. A colleague of ours in IDRC, refers to the world today as a fractured order. In that fractured order, where institutions, arrangements, processes and the very nature of international cooperation are changing dramatically, there is a clear need for new thinking and for new approaches. ENHR, we believe, is one illustration of new thinking and new approaches.

Timely, also in the sense, that in this fractured order, the role of the nation state in delivering public good is becoming smaller every day. We must look at new forms of combining resources, new ways of bringing together different players, actors and stakeholders so that the basic public good, may continue to be delivered. Development agencies also realize that they require new arrangements if they are to be part of the delivery process.

We are not certain what form the new arrangements will take. So again, ENHR is timely in that the process is an attempt to put together new kinds of arrangements, new kinds of organizational structures and new kinds of participation for the delivery of an essential public good - Health.

The second reason is **the ENHR approach itself**. It is fundamentally an inclusive and participatory one. It is certainly not top down. After 20 years of existence, IDRC realized that while we, like others, have been successful in generating an enormous stock of knowledge, the problem is less with the production of knowledge, than with its use by those who need it most.

The ENHR approach forces the researcher to sit with the policy maker and the policy user (the people) to determine what priorities and what possibilities exist. We are pleased to associate ourselves with ENHR, in that we believe it is, by the very nature of the process itself, a step in the right direction.

The third reason, is **that ENHR is no single model**; it is anything but a template which applies universally. It is a highly flexible and adaptable instrument which adjusts to the circumstances in which it is applied. As such, it is not culture bound - as many of our previous attempts at providing leadership in development have proven to be.

ENHR applies equally in developed as in developing countries, equally in richer communities as in poorer communities. In this regard, the ENHR model is being used increasingly in Canada as an attempt to come to terms with scarcer

resources, increasing costs and the need to continue to provide quality health services for all Canadians.

The fourth reason is that the purpose behind ENHR is fundamentally encapsulated in one of our cliché words - **empowerment**. The result is an empowerment of the user; the people. We hope that this is also a step in the right direction.

Now, after two years, is a time for taking stock. Where have the ENHR process and the Task Force taken us? I believe these are questions that we must come to terms with. What has the experience shown us to date? What do we have with which to assess the desirability, utility and validity of this approach? Where should we now go with ENHR, and what are the next steps?

There are two options before us: One is to move forward, and the other is to say it has been interesting, but the benefits are not equal to the cost. Therefore it is time to look for a different approach. I believe that we should be candid; the second option is on the table. However, if we are to move forward, on what basis, using which model?

I will end with two observations. One is that we should remember that two years is probably too short a time to come to a definitive evaluation of the potential of this instrument. Nevertheless, we should try to look for indicators as to where ENHR has taken us and what validity the process contains.

My second observation echoes what Tim Rothermel said. If there is strong support and consensus that the ENHR Strategy should be pursued further, we will join our colleagues at UNDP enthusiastically, and together with other partners do our very best to facilitate this pursuit.

The Swedish Agency for Research Cooperation with Developing Countries (SAREC)
Mr. Anders Wijkman, Director General

We are indeed very pleased that so many distinguished representatives from all over the world have joined us here today. We are here because we share a common concern; the need for efficient partnerships and cooperation in improving basic living conditions for many millions of people all over the world.

This century has seen many accomplishments, not the least in health and medicine. Those of us who have been fortunate enough to be born in the North

enjoy the fruits and benefits of these accomplishments. For the vast majority of the world's population, those living in the South, this is not true.

Of course, there have been some positive developments in the South, and living conditions have improved in many areas. But hundreds of millions of people still have to struggle daily with poor sanitation, unsafe water, malnutrition and repeated onslaughts of disease. Our task is to come up with new and better ideas on how to improve their living conditions and health.

In most countries in the South, resources allocated for the social sectors are extremely limited. Recent statistics from UNDP compare what is spent for military purposes with what is spent on education. The ratio is incomprehensible. Structural adjustment programs have tended to decrease allocations for health and education; sectors which are critical for development.

Both IDRC and SAREC are basically involved in one thing in the South, capacity building. We are often confronted by citizens in our own countries who ask: "why, if developing countries are so poor, can you justify spending funds for development assistance on research? Shouldn't you concentrate on other things first?" Of course, research as such cannot be a substitute for action. But action, without proper knowledge, analysis and tools runs a great risk of being inefficient and wasteful. The Commission on Health Research for Development pointed to the crucial importance for all countries to apply the Essential National Health Research concept and develop the capacity to generate the knowledge and carry out the analyses needed to solve their health problems.

I think that you are all familiar with the report which the Commission presented three years ago. SAREC was proud to be one of the two agencies asked to carry forward its recommendations. Together with IDRC, we have tried to live up to this mandate through the establishment and support of the Task Force and its Secretariat. And today we have the honour to be one of the agencies sponsoring this conference during which the Task Force will report back to you, its constituency. Let me take this opportunity to congratulate the members of the Task Force and its Secretariat for their devoted work.

The responses from countries in the South have exceeded our expectations. We look forward to sharing your experiences and to receiving your advice on how to proceed. We are also very pleased that twelve agencies in the North have supported the Task Force, and our special thanks go to UNDP for offering the use of their facilities in Geneva. The close and positive contact that the Task Force has enjoyed with WHO during the last two years also augurs well for the future.

Science is international, and the Commission called for more effective partnerships in health research. However, there is no doubt that if health research is to make a difference, it has to evolve primarily in those countries which carry the largest share of the burden of ill health. These countries have a responsibility to address their own health problems and to build their analytical and research capacity to do this.

Distinguished participants from developing countries, for me, this is your conference. Your guidance is crucial to our deliberations. While the reports and recommendations of the Task Force will be discussed at length, the establishment of a Council on Health Research for Development, as proposed by the Task Force, should come about only if you see a need for it. Only then can such a Council become a forum for true partnerships in health action.

Speaking on behalf of SAREC, we, like IDRC and UNDP, are prepared to continue giving our support; but only if there is a strong wish to continue this process among both developing countries and other development agencies. We must recognize the difficulties we all face in respect to funding. Therefore, priority setting is more important than ever. This is why the wishes of the South are of such vital importance for decisions about the future use of our resources. We will only succeed if we are united.

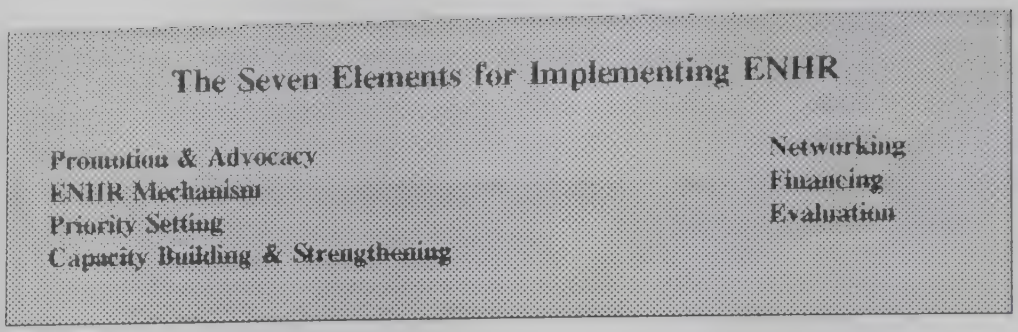
The participants selected Professor Demissie Habte as Conference Chairperson and adopted the agenda.

Setting the Stage

Professor V. Ramalingaswami, the chairman of the Task Force and a member of the Commission, and Dr. Alfredo R.A. Bengzon, former Secretary of Health of the Philippines, who began the ENHR process in his country, presented the evolution of ENHR and the opportunities which the Strategy offers for the achievement of equity in health.

***The Evolution of the ENHR Strategy*, Prof. V. Ramalingaswami.**

The Commission on Health Research for Development conceived the Strategy of Essential National Health Research, the Task Force promoted and facilitated it and the Countries have applied it - each in its own way. The first meeting of interested and participating countries in Pattaya, Thailand, in November 1990, defined seven elements of the Strategy common to its implementation. These elements remain as crucial to the ENHR Strategy in 1993 as they were in 1990.



Element I: Promotion & Advocacy

The aim is to sensitize researchers, policy makers, health care providers and the public to the need for a new strategy for managing health research. It involves promotional activities by "prime movers" who will initiate and promote dialogue at all levels of the health system and mobilize support for the new approach from scientists in various disciplines, public and private health care givers and the community at large.

Some countries have initiated this phase through a formal launching ceremony. This provides a useful opportunity to capture the attention of key groups and critical constituencies. The "prime movers" must sustain their promotional effort over a long period, and, through advocacy, obtain the involvement of the relevant groups and disciplines.

Element II: ENHR Mechanism

The aim is to create a durable, but flexible mechanism for promoting and coordinating health research. This is usually accomplished by adapting existing structures with the objective of developing a system that facilitates the interaction of researchers, health care givers and the community at large in managing health research and in applying the results of such research.

Element III: Priority Setting

ENHR implies a new approach for setting research priorities. Always keeping in mind the goal of increasing health and development equitably. The criteria for selecting priorities must be heavily weighted in favor of the poor, under-served and disadvantaged groups of the population. Objective analysis of data obtained from country-specific studies would provide a rational basis for identifying

priorities for both research and action, including the identification of problems requiring global research. The research agenda and the inventory of existing institutions and scientists would identify the need for institution building, training of research personnel and other measures such as career structures, funding and networking required for strengthening national research capabilities at all levels of the Health System.

Element IV: Capacity Building & Strengthening

Developing countries need to strengthen their capability to conduct research on issues of relevance to their national health systems and programs. Highest priority must be given to developing the capacity to carry out such country-specific research. Countries should also steadily increase their capability to contribute to global research, especially on problems that are of high priority in their geographical area.

Element V: Networking

Working in isolation often limits the effectiveness of scientists in developing countries. As part of ENHR, it is important to establish and strengthen networks among researchers from various disciplines at the national level, and to promote interaction with their peers in other parts of the world. Membership in international networks will enhance the ability of scientists to work effectively on problems of national priority.

Element VI: Financing

The objective of this element is to increase financial support for research activities and for capacity building and strengthening. And to ensure that all resources are applied effectively. Significant national contributions in funds and "in kind" to the ENHR Strategy facilitate the procurement of external assistance.

Element VII: Evaluation

A monitoring and evaluation process must be included in every aspect of the ENHR process. This will ensure that efforts have maximal impact and will indicate the need for mid-course corrections. Analysis and evaluation is also crucial for the sharing of experiences between countries and for regional and global comparisons.

The seven elements represent a "check-list" of activities that need to be considered in the implementation of ENHR. The list does not imply a linear progression from one item to the next; rather, individual countries may use these elements as guidelines for developing and operating their national programmes of Essential Health Research.

The country focus has become the bedrock of the ENHR Strategy. It is the reality within a country which predicates priorities and creates the country-specific essential health research programs. And the people must be involved in partnership with the researchers and the decision makers. Only through such partnerships will research become relevant and policies be based on sound scientific information.

The second meeting of countries undertaking ENHR took place in Kampala, Uganda, in April 1992. The participants from fourteen countries shared their experiences with the Strategy and concluded that ENHR belongs to the countries and that they should play a major role in guiding any future organization facilitating national ENHR efforts.[2]

Countries wish to have, and must have, their destinies in their own hands. They claim ENHR as one of the ways to achieve this. The countries want a new structure to succeed the Task Force. A structure to facilitate both their individual efforts and the sharing of their experiences. A structure that has financial and operational autonomy, managerial flexibility and efficiency. A structure under the umbrella of the United Nations but free from bureaucracy. The countries are ready and they have placed the challenge and the opportunity before this conference.

As the work of the Task Force comes to an end, I wish to tell you that it has been one of the greatest privileges of my life to be associated with the Commission, the Task Force and the birth of the ENHR Strategy.

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[2] *Report of the Africa and "ENHR" International Conference*, Ministry of Health and the Uganda National Council for Science and Technology, Kampala, Uganda, April 1992.

Catalyzing Spring,
Alfredo R.A. Bengzon M.D.

There is an American song that says "love is lovelier the second time around." Three years ago, at the Nobel Conference in Stockholm, I was asked to deliver the Summation address. Although it was my first introduction to ENHR, the task was not difficult. All I did during the preceding two days of plenary sessions and workshops was listen, reflect and learn, and then simply respond. The magic of the moment that surrounds the launching of something new, creative and challenging made it easy to be enthralled and enthusiastic.

Now I am asked to deliver the Keynote address, before any of the sessions in which will be discussed the progress of the past 36 months and the prospects for the future. We have before us an excellent summary prepared by Dr. Richard Wilson and the Task Force Secretariat, and Prof. Ramalingaswami has just finished giving us a clear and concise overview. To them and to the other moving spirits of ENHR, we are all most grateful.

Three years ago when I addressed you, I was Minister of Health of the Philippines, well into the second half of my term, concentrated on consolidating our gains, addressing the gaps and preparing the mechanism for succession. Now having retired from that position, certainly an older and hopefully wiser public voice from the private sector, I am actively engaged in reflecting on the lessons of these past six years, the better to apply them for present and future uses.

The enthusiastic response to ENHR, surpassing all expectations, makes my task this morning "lovelier." But our individual and collective assignment these next two days is to keep our feet firmly planted on the ground even as we keep our eyes towards the horizon and into the future. I believe that in order to sustain the momentum, we must confront the difficult questions. So let me start along that path.

For more than a quarter of this century there have been many calls for reforms in health. In conferences and workshops, through papers and presentations, via global summits and community gatherings, in public as well as private sessions, these calls have been sounded and articulated at national, regional and global levels.

Reforms are called for in the way health is defined and understood, perceived and projected; in how policy is formulated, priorities established and programs

pursued; in how resources are generated and especially in how they are allocated.

These calls for reform come under different guises: Inter-sectoral Collaboration, Cost-effectiveness, Capacity-building and Sustainability, Advocacy and Effective Communication, Response to Global Change, and indeed, Essential National Health Research.

But no matter what names they bear, these calls are driven by the same concern: how to do a better job in caring for the poor, the marginalized, the disadvantaged and the powerless. The common cause then is Equity, among and within nations. What is our track record?

Within the health sector, amongst ourselves, we have done respectably well. The examples are there for all to see. But outside the health sector, in the larger world of governments and societies, amongst competitors rather than colleagues, we have not done as well. Using, as an indicator, the percentages of national or global budgets that go to health, or the levels of investments that come into our sector from development agencies, we are forced to sadly conclude that, with some exceptions, we have not become the major player that we can and should be in national and global development.

I am constantly puzzled by this situation and have repeatedly asked why this is so. After all, health, as a reflection of life and its quality, is a core value. Health professionals arrive at notions and concepts using scientific and rigorous methods. Health workers are, by and large, selfless and dedicated, industrious and imaginative. If our cause is just, our hearts pure and our services vital, why do we not have the ascendancy that seems so richly deserved?

In the years of grappling with that question, I have come to the conclusion that it is because we have lived in our own small world, safe with our concepts, secure with or technology, content with our own lingo and comforted by the nobility of our cause as we carry out our functions. In our desire to be self-sufficient, we have become self-absorbed, and our own small, safe world has become our prison.

We have been shy, timorous, unconcerned with and disdainful of "dirtying our hands in realpolitik": that world of competition for resources, where the appropriate, and sometimes inappropriate, use of power can make the difference. I grant you that it is often a dark and vicious culture. But we must have both the wisdom and the humility to recognize that more often than not, it is there where the battles against inequities are waged and won.

Allow me to illustrate. A survey of the landscape painted in a recently concluded World Bank-sponsored meeting reveals no shortage of challenges. Consider the following areas crying for reforms: (1) increasing the share of government spending in health; (2) redirecting public spending to cost-effective interventions; (3) improving the technical efficiency of public spending; (4) encouraging community financing of health care; (5) rationalizing selection, procurement and use of pharmaceutical products, medical supplies and equipment; (6) improving regulation of the private sector; (7) paying providers in ways to help control costs while maintaining efficiency incentives and professional autonomy. And there are many more.

When you remove the cover of those polite and professionally crafted words, you discover that common to all of these areas crying for reform is this: in order to move forward, we will need to rock the boat, to question, challenge and change established ways of thinking and doing. And in so doing, it is inevitable that we confront those who would preserve the "status quo." As we strive to increase our share of the resource pie, we will have to come up against other power blocks with interests traditionally judged to be more worthy of support than ours such as the military and their focus on national security; or the economic planners and their call for structural adjustments to control inflation and reduce deficits, such adjustments purportedly requiring short term sacrifices to achieve long term gains. As we work towards redirecting the focus of health towards cost-effective, preventive interventions, we will have to persuade the medical establishment that health care is much broader than just sick care or hospital care. As we seek rational drug use, we will have to contend with the globally powerful pharmaceutical industry. As we aim to promote family planning and responsible parenthood, and confront the AIDS pandemic we will no doubt have to face the powerful Roman Catholic Church.

Are we equipped or even inclined to make such waves? Do we understand or care to understand the processes of decision-making in the body politic? Do we know how to apply our knowledge as a competitive advantage in the power struggle for recognition and resources? Have we even recognized it as such, a power struggle, an arena where we, in effect, need to do battle to move our cause forward.

If we have been absent from this arena, worse, if we have chosen to be absent, how can we possibly expect to be a presence to contend with?

There is another consequence of our having become so self-absorbed that is just as disturbing, if not more so. I believe that, in addition to being removed from the circles of power, we may have isolated ourselves from our constituents. Our

work may have become sanitized and sterilized, divorced from the intense realities that it seeks to address. In the pursuit of scientific truths and technological advances, we may have lost sight of the fundamental reason for our intellectual forays, the betterment of the human person.

The traditional view of research reflects this self-imposed seclusion. We are familiar with the stereotype researcher - a white-smocked scientist working out of an immaculate laboratory, having more interaction with animal specimens and computers than people. His grave demeanour and constricted affect manifests his single-minded and noble pursuit of the facts. He may be intense and passionate, but the object of his intensity and passion is his work, not the persons who will be, or should be, the ultimate beneficiaries of that work. Because we have avoided jousting with the prince and the merchant, we may have also forgotten the citizen.

It is therefore inspiring, exhilarating and poetic justice, that a movement as essentially dedicated to research as ENHR, should in the concepts and approaches it has adopted, present a radical paradigm shift, and in doing so, point the way out of this insulation and isolation.

To those who dedicate themselves to the pursuit of reform, ENHR has much valuable advice to offer. National focus is the starting point, for this is where the real day-to-day playing fields are. But even as each country's uniqueness is recognized, given its own historical, social, cultural, political and economic situation, there must be appreciated and brought to bear the value and practical help of the international community.

In approach, ENHR shows that reform should be expansive rather than restrictive, drawing alliances from many disciplines, especially the social sciences, which help one better understand the behaviour of individuals and communities.

Most importantly, ENHR teaches that, in operation, reform should be inclusive rather than exclusive, breaking out of traditional molds and stereotypes, to include many interests and persuasions, even if, or precisely because, they may be conflicting. ENHR shows us that research need not always be in vitro. It bids us to leave the comfort of our laboratories and offices and consult with communities of people who have first-hand experience with the problems we seek to address. They have insights, born out of common sense, intuition and experience, that can lead to the development of down-to-earth solutions. It is only by seeing the world through their eyes that our passion for their welfare is enkindled and our role as their advocates legitimized.

Further, ENHR works towards bringing health and health-related issues to the forefront of national and international concern by involving policy-makers and other power centers, making them stakeholders in its operations and output. It provides a platform and a vehicle through which we can contribute to, and benefit from, national policy formulation. It enables us to join the mainstream of the development process and put forward our agenda on behalf of our constituents.

As I stated in my summation in Stockholm three years ago, ENHR is an idea whose time has come. We have indeed begun a revolution, a new way of thinking, feeling and acting, whose application goes beyond the area of health.

In my country, for the past few months, a process has been underway in all of our 75 provinces. A core group of conveners from the government, religious groups, NGOs and People's Organizations (POs), have gathered representatives from each province to consult them on ideas, experiences and aspirations towards the forging of a just and lasting peace. While the initial impetus came from the National Unification Commission, a government ad-hoc body set up by the President to initiate dialogue with the rebels of the Right and the Left, the people in the communities have seized that opportunity to make their contribution to the formation of a national agenda for peace.

In these sessions come together representatives of national and local groups, public agencies and private communities, people from the military as well as civilians, members of the Executive as well as Legislative branches of government, representatives of many religious groups, NGOs and Peoples Organizations. The issues and messages are familiar to us all; poverty alleviation, structural change, land and aquatic reform, a more equitable distribution of power and resources, good governance and access to basic services, including health. I am familiar with the process, for the key persons in the Secretariat responsible for its design and implementation were colleagues of mine while I was Peace Commissioner. The principles and strategies underlying our peace process are very similar to those of ENHR. There must be a lesson there somewhere.

I must ask now, what will it take to forge ahead in our pursuit for equity through reform? ENHR has helped write the script. Now we must find the actors. Revolution is born in the mind, brought to life in the heart, but is sustained in the sinews of men and women. We need a cadre of leaders to marshall all the evidence and argue our cause, leaders who will be the voice of conscience, urging the developed nations of the North to alter the magnitude and direction of resource flows to favour the developing world. For ultimately,

resources define the possible outcomes. Political will and management skill can only assure what resources will permit.

But more than that, we need kindred spirits to lead in the process of reform, combining talent with technique, complementing science with savvy, completing technology with wisdom, as we move to communicate, persuade, mobilize, galvanize, light a fire within the health sector, and more importantly, in the larger world outside.

Such leaders do not emerge by accident. There must be a systematic, deliberate and committed effort to identify them, nurture them, and invest in their development, individually and collectively. Such an effort has, thus far, been sorely absent in our sector, and so we should not wonder why as loud as the calls for reform, are the cries for leadership. Perhaps ENHR will once again serve as the catalyst, the vehicle, for developing reformers for reform.

Three years ago when we first came together in Stockholm it was in the depth of winter. Now here in Geneva, as we look to the future, it is still winter, but we await the coming of spring.

Country Experiences

These were the heart of the Conference. Each of the countries participating in the conference presented their experiences with ENHR and their country's plans for future health research and how to carry it out.

The ENHR Strategy is first and foremost, a national strategy based on the premise that every country should be able to determine its health problems, set its health research priorities and assume responsibility for the health of all its people. Therefore, the views of countries regarding the Strategy and their experiences in applying it, were the core of the conference. The decision to continue the facilitation of ENHR and establish COHRED with a Board having a majority of members from countries in the South arose directly from the enthusiasm for the Strategy expressed by the countries - each in its own way.

Representatives from 18 countries or groups of countries reported on their experiences and progress with ENHR, and on the state of health and health research in their countries. The countries were: Bangladesh, Benin, the Commonwealth Caribbean Countries, Egypt, Ghana, Guinea, India, Kenya,

Mexico, Mozambique, Nicaragua, Nigeria, Pakistan, the Philippines, Tanzania, Thailand, Uganda, and Zimbabwe. In addition, a group from South Africa presented ENHR activities in that country.

Although each of the countries is unique in its health problems and resources to meet them, all are committed to the concept of ENHR and are carrying it out in different ways determined by national circumstances. All recognize the potential of national research in solving national problems of health and development, and in making progress towards equity. ENHR is viewed as a long-term process, one which introduces the element of scientific enquiry into priority setting, planning, operations and evaluation.

Those countries having significant resources for research reported that previous research topics were frequently not related to national health needs and failed to provide information needed for government health planning and policies. Some countries including Bangladesh and Thailand had already begun to take steps to remedy this situation prior to the advent of ENHR. However, in most countries, the ENHR Strategy has provided the stimulus and framework to begin this process. Countries having little or no antecedent research capacity, such as Benin and Guinea, are now beginning to develop research plans and capacities, on the basis of an ENHR framework.

In many countries, a workshop or series of workshops has provided a foundation for interaction between decision and policy makers and researchers to launch the ENHR process. In most countries these workshops have been attended by community representatives. In countries such as Benin and Guinea community consultation and participation began at the earliest stage, whereas in others where there was a pre-existing strong research establishment such as Mexico, the Philippines and Thailand community consultation occurred later in the process.

Eleven countries reported the establishment of an ENHR institutional mechanism as the promoting, planning and coordinating body. In all cases, the mechanism has ties with governmental and research bodies. Sometimes the mechanism is a non-governmental organization (NGO) with strong government backing and connections. For example, the Egyptian Society for Health Research for Development is an NGO with a board comprised of members who are senior government officers, health officials, members of academia and researchers. In Thailand, the ENHR mandate has been adopted by the National Epidemiology Board (NEBT), set up prior to the advent of ENHR. The NEBT is an NGO established by government with members from government bodies, Universities and the Ministry of Public Health. Sometimes the mechanism is a governmental

body. In the Philippines, the Department of Health played the lead role until the para-governmental ENHR Foundation was established. The form of ENHR mechanisms depends on national health services, research structures and upon the personalities leading the ENHR initiative.

Likewise, the pace of development of ENHR planning and activities depends on national circumstances. In some countries, such as Mexico, the Philippines, Thailand and Zimbabwe, significant research resources existed already which could be incorporated or adapted to lie within the ambit of the ENHR Strategy. In other countries, such as Benin and Guinea, there was little or no antecedent research base and few resources. In these countries, the ENHR process has developed more slowly, but structures are now being set in place. A common feature of countries having significant research resources is the perception of the need to build national linkages and cooperation between researchers and health workers, so that research projects could be oriented towards the country's needs and the research findings used to improve health services for all its people.

Many countries emphasized the constraint of an inadequate or nonexistent research capacity and regarded its development as an early step in implementing the ENHR strategy. Training is a key element in building capacity and it comes in many forms; from doctorate training for research professionals to short workshops or courses for all levels of health workers. Some countries place special emphasis on the latter approach. To quote from the report from Bangladesh: "The myth that research is expensive and a luxury only for a selected few must be eliminated. Research can be of short duration, affordable and simple, and should always have the ultimate objective of improving the life of the people."

Many country presentations included a review of national health status and health programs as well as antecedent research and constraints. The following are summaries of the accounts of progress in the evolution of the ENHR Strategy in the country presentations.[3]

Bangladesh

An ENHR secretariat has been established under an ENHR Working Group, having members experienced in operational research and health care planning.

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[3] More complete versions of the country presentations are available from the COHRED Secretariat.

An ENHR National Forum of senior scientists and health administrators has been set up to strengthen advocacy of ENHR at the highest levels. Activities included:

- Capacity development through research awards to young investigators for training in research proposal development, data analysis, preparation of reports and for training in epidemiology and biostatistics;
- Dissemination of research findings through publication, compilation of theses and through workshops on research findings;
- Advocacy of ENHR through meetings of the National Forum and through issue-based workshops at national and district levels;

Benin

ENHR development started with a series of seminars and Search Conferences to identify problems of health and development at the village level. These culminated in a National Workshop in 1991 which selected 30 of the 252 previously identified problems as of highest priority. A number of ENHR groups have been set up; one national, six departmental and seventy-seven local. Three departmental seminars for training in research methods were held in January 1993, and a 5 year ENHR plan has been prepared. ENHR planning is in the hands of Le Centre Beninois pour la Recherche Scientifique et Technique, with strong support from the Government, especially the Ministries of Health and Education.

The Commonwealth Caribbean Countries

This group consists of 18 politically independent states and British affiliated dependencies, with wide variations of race and colour, resources and capabilities, as well as religions and cultures. In view of the size of the states and their limited resources, it was essential that health research be a collaborative endeavour. The Commonwealth Caribbean Medical Research Council is the central agency for ENHR. The Council is responsible for health programs and for supporting research. At the beginning, support was given to investigator-initiated research unrelated to health needs. However, some six years ago a policy was introduced which based research on health needs, and this formed a precursor to the ENHR concept. A Caribbean research network developed with both internal Caribbean and external links.

As part of the process of establishing ENHR, two workshops were held in 1992, and in 1993 a five year ENHR plan for the region was prepared. It is hoped that a Commonwealth-wide ENHR Council will be set up.

Egypt

The Egyptian Society for Health Research for Development (ESHRD) was established in 1991. It held two national workshops in 1991 to promote ENHR, to develop new ideas and to recruit members. It helped in planning for the third National Development Plan (1992-1997). The Alexandria branch of the ESHRD selected two priority health problems for study: child labour and its abuse; and environmental cement pollution. A register of research centers and activities is being compiled. In 1992 a conference on Health Priorities included policy makers, scientists and community representatives. Subsequently the Society decided to implement local research in several provinces in a diversity of settings and identified four priority research areas: chronic health problems; problems related to poor sewage disposal; child abuse; and enhancement of community participation initiatives.

Ghana

There is a long standing tradition of research in Ghana, but its focus has been largely biomedical. The need to develop and improve health research had been clear for some time. In 1990, a situation analysis was conducted with support from the Health Systems Research Programme of WHO. Recommendations were made for improvements including the training of manpower, strengthening institutions and the promotion, coordination and utilization of research. A Health Research Unit was established within the Ministry of Health. An ENHR workshop took place in February 1992, with participation from research institutions, universities, policy makers and the staff of the Ministry of Health. Another planning meeting took place in December 1992. It is intended to produce a "rolling" ENHR plan, consistent with the national health plan and priorities. If the necessary financial support is available the plan should be completed by late 1993 and implementing should begin in 1994.

Guinea

Prior to 1988 there was virtually no research in progress in the country. In that year the Ministry of Health established a Unit of Research Training, and a

seminar on the Methodology of Operational Research was held in 1989. However, there was little or no coordination between activities, nor were there defined objectives relevant to the improvement of health. Subsequently plans were made to adapt the ENHR strategy.

Decision makers, the community and research workers have taken part in the planning, which has been on the basis of field visits, semi-structured interviews and five regional workshops. These led to a national workshop for developing an ENHR policy. A plan for the period 1993 to 1997, defining ENHR strategies, activities, indices for evaluation and required resources has been prepared.

A consultative committee will implement ENHR policies and training programmes and will support research projects. A technical and coordination service will provide logistical support, undertake financial negotiations, provide documentation and information, coordinate research training as well as analyze and disseminate research findings.

Constraints include: inadequate training of researchers; insufficient national resources and thus the necessity to seek outside support; difficulties in integration of multisectoral approaches; and some lack of political will to use research findings.

India

There is a substantial capacity for research in India, but coordination is often lacking. An ENHR Symposium in 1991, sponsored by the Indian National Science Academy and the National Academy of Medical Sciences, underscored the importance of participatory community research at the grass-roots level. In February 1992, a National Workshop on "ENHR Priorities and Capacity Building Needs" paved the way for the launching of ENHR. Formal collaboration was established between BAIF and the K.E.M. Hospital Research Centre, Pune - two NGO's working on problems of development and health at the village level.

In June 1992, project planning began on "Needs assessment of rural women as perceived by them." A combined project has been developed by BAIF and the K.E.M. Hospital Research Centre, and is awaiting funds. In addition the Sarvothum Foundation has held workshops on the ENHR Strategy and on action plans to implement the strategy. Thus current and proposed activities in two large Indian States are in the hands of NGO's, with the approval and support of the Indian Council of Medical Research.

Kenya

The current health objectives of the government include conducting biomedical and health services research to identify more cost-efficient and cost-effective methods for the delivery of health services. The ENHR initiative is being built on a substantial antecedent research base, including the Kenya Institute for Medical Research (KEMRI) and the Kenya Trypanosomiasis Research Institute (KETRI).

A Convention held in 1991 concluded that research activities were uncoordinated, that there was no agenda for ENHR and that resources were inadequate. An ENHR Task Force was set up, with a small secretariat, to stimulate networking, prioritize research programs and objectives, review proposals for funding, promote research documentation and the application of research findings and encourage training for ENHR. On the basis of a community survey in 1992, an ENHR priority list was prepared to cover the following five years. These priorities include: Maternal and Child Health/Family Planning, Water and Sanitation, Health Care Delivery Services, Sexually Transmitted Diseases and AIDS as well as training and related capacity strengthening activities. An inventory of health related research over the past 10 years is being prepared. A Convention held in 1992 approved a 6 year master plan prepared by the ENHR Task Force, to begin in July 1993.

Mexico

Mexico is in a stage of protracted epidemiological transition. In general, infectious diseases have been brought under control, but chronic diseases and injury are increasing in frequency. Emerging problems include AIDS and the diverse health effects of environmental pollution, and cholera is resurgent.

Although in the past, Mexican scientists have made significant contributions to medical knowledge, a conflict has existed between individual research preferences and country health research needs. This resulted in a restricted use of research findings for decision making. This in turn, led to the creation of the National Institute of Public Health (NIPH) and the Advisory Board in Epidemiology (ABE).

The NIPH was founded in 1987 by the merger of the School of Public Health, the Centre for Research on Infectious Diseases and the Centre for Public Health Research. Its task was to contribute to the improvement of health by the production, dissemination and utilization of scientific knowledge. The ABE was

founded in 1989 as an independent multidisciplinary group of researchers. They advise the Secretary of Health on policy and programs for disease prevention and health promotion based on research into communicable diseases, chronic and degenerative diseases, substance abuse, environmental health, reproductive health and quality of care.

Examples of problem-oriented research include a series of randomized trials of measles vaccines in children, aimed at improving the protection of infants and finding more effective ways to revaccinate school children and a study of HIV transmission through paid blood donors, who were found to be an important source of transmission of infection. Following the latter study, commerce in human blood was prohibited, a national system of laboratories for HIV detection was set up, and a public program for safe blood donation was established.

A System of National Health Surveys was created in 1985 to provide information on health-related conditions at household level, using sample sizes which were large enough to be representative at national or regional levels. Topics studied included general health conditions, diarrhoea in young children, oral dehydration salts therapy, drug abuse and addiction and the nutritional status of small children and women of reproductive age.

Following the work of the International Commission on Health Research for Development, Mexico established the National Commission for Health Research (COMISA). It is a non-governmental organization, hosted by the Mexican Academy of Sciences, which aims to promote health research for development on an interdisciplinary base. A medium-term plan for ENHR is in preparation, and priority areas have been defined along the lines previously suggested by the ABE. The plan integrates research in biomedicine, clinical sciences and public health, with recommendations on the required financial and organizational support.

Mozambique

In October 1992, at the end of the civil war, Mozambique had created conditions for normal living and thousands of people returned to their homeland to start a new life. Thus the National Health Service (NHS) was now accessible to the vast majority of the population. However, under current harsh economic and financial conditions, government expenditure for the health sector has diminished dramatically.

There is great dependence upon foreign aid for the routine operational costs of the NHS. This applies also to research. This dependence raises many problems including that of long-term sustainability.

Salaries for policy makers, health managers, professors and researchers are very low. These people need motivation, including adequate salary levels, if they are not to be lost to private sector activities or private clinical practice.

There is a need to establish a dialogue between researchers on the one hand and policy makers and managers on the other. At present, research is mostly bio-medically or epidemiologically oriented, and there is little health systems research.

How would it be possible to have a multidisciplinary research approach in a country where there are only 250 Mozambican doctors to serve 16 million people, and where social sciences are only now beginning to be introduced through a handful of social scientists?

In spite of these problems many ENHR activities are in progress, mainly in the fields of training, information, documentation and some research activities. Under the Southern Africa project, the training of district level health staff in Health Systems Research has been very successful. This project is supported by the WHO and the government of the Netherlands while other ENHR activities received support from IDRC and SAREC.

Nicaragua

In 1987, a National Plan of Health identified science and technology as a key need for the health sector. In 1992, a National Commission approved a Work Plan for ENHR, including seven Systems of Local Integral Health Care (SILAIS). Coordination was established between various groups of investigators.

Seven workshops have been held on SILAIS, with participants from the Health Ministry, the community, research centers and schools. Each workshop has established a SILAIS area, and on that basis, a first listing of national research priorities was prepared.

The First National Workshop on the ENHR strategy was attended by health officials, research workers, community representatives and development agencies. The following were discussed: an ENHR national plan; the Strengthening of Research Capacity; the distribution and use of research

findings; and ENHR mechanisms.
The main conclusions and recommendations were:

- a consensus on the need to elaborate and implement an ENHR plan;
- the creation of an Executive Secretariat of the National Commission;
- the strengthening of groups of research workers to study national and local problems;
- the strengthening of research capacity with respect to human resources, finance, and national and international cooperation;
- a review of available resources and factors that affected their development; and
- continued promotion of the ENHR strategy.

Nigeria

In 1988, Nigeria began to implement a National Health Policy based on the establishment of a three-tiered National Health System. This consisted of Primary Health Services at the village and local level, Secondary Care Services comprising general and district hospitals and Tertiary Services including teaching and specialist hospitals. It was intended to enhance this development by application of the principles of ENHR.

In 1992, a Working Group was set up to prepare a plan for National Health Systems Research. A unit to organize and promote health research was established in the Department of Research and Statistics within the Ministry of Health. This unit now requires strengthening and adequate resources.

The Working Group recommended the establishment of a multidisciplinary and intersectoral Technical Advisory Panel on health research at the Federal level to advise on priority setting, advocacy, guidelines for research proposals, provision of technical support and collation of information. This panel will be under the chairmanship of the Minister of Health. Similar groups will be set up, at the State level to promote research at the Secondary Care level. A mechanism was also proposed for research at the Primary Health Services level.

Pakistan

The Pakistan Medical Research Council (PMRC), established in 1962, had by 1990, established 17 research centers in leading medical colleges and postgraduate Medical Institutions. Most of these were conducting biomedical and clinical research. Three Health Services Research Centers have also been set up and a National Health Survey was conducted in the late 1980s. However, it was appreciated that there were no effective linkages between health services and research.

Accordingly, a national workshop on ENHR was held in 1991 to review needs and programme possibilities for health research. Its report, *Health Research in Pakistan: Action Plan for the '90s*, designated the PMRC, under the Ministry of Science and Technology, as the implementing agency. And the PMRC modified its structure accordingly. A National Health Research Structure and Technical Advisory Groups have been established at the federal level and Provincial Coordinating Bodies at provincial levels. These groups have representation from agencies in the public and private sectors and include researchers, decision makers and community/public representatives. They will identify priority health problems and research questions as well as design and conduct research.

The Philippines

An Ad-Hoc Committee to start planning ENHR was formed soon after the Nobel Conference in 1990. This was followed by a workshop attended by officials of the Department of Health and health professionals from both academia and the private sector. A conceptual framework for ENHR was developed and presented to the ENHR Conference at Pattaya late in 1990.

The ENHR Unit was then established in the Ministry of Health, with the Undersecretary of Health as the Program Manager. An expanded Working Group met in February 1991 to develop the ENHR program concept and in July of that year five consultative groups of experts were set up, based on the main areas of responsibility of Department of Health. In addition, following feedback from experiences in ENHR development in Africa, consultations were held with NGOs and People's Organizations. These identified sixty eight "Problems, Issues, Needs and Concerns of people" (PINCs) requiring research. In a second stage broad-based, multisectoral discussions identified many problems relating to specific illnesses, health service delivery and help-seeking behaviour.

Participants at the National ENHR Workshop held in 1992 included representatives from the people, NGO's, policy makers and health programme managers, biomedical scientists, clinicians and social scientists. An agenda for ENHR was prepared for the period 1993 to 1997, including:

- organization and management of the delivery of health care;
- economics of health care;
- individual and public health care in infectious disease, emerging diseases and the problems of marginalized and under-served groups (The need for inclusion of these topics was expressed vigorously during the peoples' consultations.); and
- health product research and utilization.

Success in achieving this agenda depends upon building the necessary research capacity.

The Department of Health plays the lead role in promoting ENHR. There is a secretariat, a steering committee and an Advisory Board with representation of medical schools, social science groups, professional societies, NGO's and research councils and institutions.

Other activities included:

- the ENHR unit made available an inventory of health research and health research manpower;
- a five day workshop on participatory action research (PAR) involved managers from NGO's and staff members of the Department of Health. PAR projects were to be developed in communities; and
- a semi-governmental Foundation had been set up to receive and disburse funds for ENHR activities, and in 1993 the Department of Health provided US$400,000 as start up funds.

South Africa

Three South Africans presented the current movement towards applying the ENHR strategy in that country.

Historically, scientific research in South Africa has had little impact on the health of the majority of the population. Excellent laboratory science has not

benefitted the health of the public, nor promoted equity in health. For example, the healthiest 20% of population has an Infant Mortality Rate below 8; whereas one third of population has a rate of 80. Public health training had been neglected. There are no university departments of epidemiology, behavioral sciences related to health, health economics or environmental public health.

There are considerable potential resources for ENHR in bodies such as the Scientific and Industrial Council (SCIR), the Human Sciences Council (HSRC), state laboratories and semi-private research groups. The pharmaceutical industry carries out research valued at twice that of the Medical Research Council's annual budget. None of these bodies have achieved community engagement. However, the policies of the Medical Research Council are changing. Support for applied community based research has increased from 8% in 1988 to 45% in 1993 of an annual Council research budget of $18 million.

Two NGO's, the South African Health and Social Sciences Organization (SAHSSO) and the National Progressive Primary Health Care Networks (NPPHCN) have reviewed the ENHR strategy at a national workshop, a national health policy conference and at the national executive level. They have expressed enthusiasm for the Strategy, emphasizing the aspects of community participation and capacity building. It is hoped to set up a National Forum of all interested parties, including the Centre for Health Policy (CHP) and the Centre for Health and Social Studies (CHESS), to plan an ENHR program involving the community and with emphasis on capacity building.

In summary the past 18 months have seen:

- major efforts to promote the ENHR concept;
- three separate priority-setting exercises;
- emerging efforts at capacity development at both the community and professional levels;
- stated commitments to ENHR from the MRC and from the broad democratic movement; and
- the establishment of a Trust Fund to support comprehensive health systems development.

South Africa is at an early stage of developing its ENHR process and several relevant activities are in progress. A convergence of efforts is needed to overcome political divisions, to evolve a shared vision of ENHR, to learn to debate and tolerate differences in approach and to ensure community partnerships and participation.

Tanzania

Prior to 1990, research was conducted in a number of national institutions, but there was no system to ensure that research was relevant to national needs and little collaboration between research workers.

In 1990, the National Institute for Medical Research (NIMR) convened a workshop to identify priority research areas and its recommendations were used to formulate the Five Year Research Programme, 1992-1996. Following the Mweya ENHR Workshop in Uganda in 1991, at which a representative of Tanzania participated, an ENHR Organizing Committee was formed with representatives from the Ministry of Health, the NIMR, the Muhimbili Medical Centre, the Tanzania Commission for Science and Technology and the Faculty of Arts and Social Sciences from Dar es Salaam University. This Committee convened the first ENHR Workshop in 1992, involving researchers and research clients. Following the Workshop, a Tanzanian ENHR Task Force was formed with the Chief Medical Officer as Chairperson and a secretariat in the National Institute for Medical Research. The Task Force is preparing an inventory of national research, analyzing health statistics to determine major causes of morbidity and mortality and holding group discussions to identify priority research areas. The Task Force is also developing a fundable research proposal on determinants of the sustainability of the national expanded programme of immunization within the primary health care infrastructure. A second ENHR workshop is planned for 1993[4] to discuss the findings of the Task Force and determine further action.

In February 1993, the NIMR held a seminar on Malaria Control Research. The 192 participants included researchers, health workers, trainers of health workers, health related NGO's, representatives of populations at increased risk, policy and decision makers and media representatives. The workshop made twenty two recommendations on malaria control and research.

Thailand

The very substantial medical research facilities developed in Thailand over the past several decades have been strongly oriented towards biomedical research. There are critical gaps in the lack of demand for research by decision makers at all levels and lack of policy orientation for research. The National

[4] This took place in June 1993.

Epidemiology Board of Thailand (NEBT) was established by the Ministry of Public Health in 1985 to identify priority health problems, to request research proposals, to select appropriate projects and activities, to allocate resources and to act upon the findings.

The NEBT adopted the ENHR strategy in 1990. Key elements enhancing ENHR activities were: the vision of academic leaders; the existence of multidisciplinary capacities enabling an immediate start; membership of NEBT drawn from government bodies, universities and the Ministry of Public Health with freedom of expression without bureaucratic pressure; an ability to handle "hot issues" as seen by administrators or the public; the dedication and commitment of the secretariat personnel; the existence of a peer review mechanism; and the full-time services of professional experts to provide leadership and management.

The NEBT proceeded from problem identification to the acquisition of knowledge and its application. Use was made of expert groups, state of the art reviews and technical forums. Research teams were commissioned to work on defined problems. Emphasis was put on research quality and the application of new findings. Achievements of NEBT are noted below.

- Many of the policies and strategies advocated by the NEBT have been adopted by government. These include vaccination against Japanese Encephalitis in provinces in the north, withdrawal of injectable typhoid vaccines from the national EPI program and modification of national strategies for the control of iodine-deficiency disease.

- Linkages have been strengthened between the Ministry of Public Health and academic institutions.

- Researchers and experts have been reoriented towards priority health problems.

- The book, **Review of the Health Situation in Thailand: Priority Ranking of Diseases**, was published in 1987 and a second edition is in preparation.

Uganda

In the mid 1980s Uganda began a process of rational health policy formulation and in 1989 a health policy review Commission made recommendations which formed the basis of a White Paper on Health Policy. The major problems were

shortage of funds resulting in lack of supplies and utilities, dilapidated infrastructure and an inappropriate orientation of activities with respect to health problems. These and other limitations brought about the realization of the need for health research as a tool for development. The Cabinet endorsed the ENHR strategy and adopted it to re-orient research towards national concerns and issues.

Following the introduction of the ENHR process in 1991 and a subsequent consensus building Conference, an ENHR plan was prepared. It seeks to shift resource allocation in favor of more cost-effective health promotion and disease prevention activities. It aims to develop a sustainable research culture; identify research priorities through consultation with stake-holders; maximize local inputs and attract external funding; and strengthen institutions and networks through a strong national ENHR body. There is now a network of technical working groups, institutions, universities and communities which is engaged in priority research in line with the first draft of the ENHR plan.

Zimbabwe

Formerly research in Zimbabwe was uncoordinated. One analysis showed that only 2% of university research was relevant to programs of the Ministry of Health. A national ENHR Committee has been established as a subcommittee of the Medical Research Council of Zimbabwe which itself has statutory responsibility for all health and health-related research under the Research Council of Zimbabwe. The theoretical framework for the ENHR strategy has been reviewed. Research is being prioritized according to geographical region, level of authority and disciplines. Local authorities are involved in the identification of priorities, and are encouraged to solicit the views from non-health sectors such as agriculture.

ENHR is being approached in the three phases. They are detailed below.

- Consultations with program managers, academics, health policy analysts and international health organizations. Training of provincial and district health teams.

- Identification and refinement of research issues at rural, district, provincial and national levels. An initial checklist of 20 broad issues for research has been circulated. The Principle Investigator of this project visited different areas to explain the checklist and receive feedback. As data was generated, identified research issues were referred to selected participants for ranking and prioritization.

- Finally a consultative meeting of research experts reviewed the proposals.

Progress has been limited by meagre government resources. At present, only donor funded activities are assured of proceeding uninterrupted. However the ENHR process is continuing.

Observations

The country presentations were the highlight of the Conference and only brief summaries are presented here. The diversity of ideas and approaches was striking and once again confirmed the country specificity of the ENHR process. Additionally, the soundness of the principles of the ENHR Strategy was reaffirmed. The need for inclusiveness and the crucial role of the people, the ultimate beneficiaries of the results of research, was emphasized repeatedly in concert with the need for research to be relevant to a country's problems. All countries emphasized the need to strengthen research capacity and many stressed the need to strengthen participatory research capacity within communities. All countries and groups realized the urgent need for intra-country linkages and dialogue but the approach to building partnerships with national nongovernmental organizations and peoples organizations varied widely.

Countries with existing research structures and institutions as well as information on health status, tended to consult and involve the people at a later stage than those countries with little or no research structures and information. However once the partnerships among researchers, the health services managers and the decision makers and the peoples groups were established they functioned well. Inevitably the participation of the people led to a modification of priorities. Such effective partnerships are dependent upon the national political and social environment and whenever any of the partners are afraid to speak openly the ENHR process stops.

It is almost self-evident that most national health research priorities established through the ENHR process aim to solve the health problems of today. However, in most instances a large part of the existing health research effort is focused on longer-term health problems. The ENHR process clarifies such potential conflict. It enables a country to establish research policies and plans which aim to solve not only the problems of today but also those of tomorrow and the more distant future. The Strategy also enables countries to create an Essential Health Research Portfolio which meets its needs for applied research in the field as well as basic research in the laboratory, and is within its financial means.

Today's health problems nearly always require policy analysis and health systems research at the community level which have not had major emphasis in many countries. Therefore in many instances these skills must be developed. Some countries realize the need for a balanced research agenda and associated research establishment, to enable them to solve the problems of today and those which they will face tomorrow. However most countries in Africa lack the funds to implement even a modest essential health research program and little will happen until some national resources for health research become available. The provision of additional financial resources to enable countries to carry out their ENHR plans is a challenge for the Donor Community.

The West African participants stated that countries are enthusiastic about the ENHR Strategy because it meets needs determined by health authorities, the communities and researchers. While the countries will establish national policies and mechanisms to plan and implement the Strategy, they need resources to carry out their essential health research. These resources should not to be tied to the research needs or policies of other countries or groups.

Countries will work together on the basis of their essential health research needs to formulate the international and global research agendas. These will evolve from the "bottom-up", and countries will encourage their researchers to participate in the resultant international research programs and projects.

At the Conference:

The debate following the presentation of the country experiences focused mainly on questions raised by donor organizations and agencies. These were answered by country representatives. Thus, this section has been arranged in a question and answer format.

The debate gradually led to the consensus that the facilitation and coordination of the ENHR strategy should be continued and that possible mechanisms for its operation should be considered by the Conference. The discussions culminated in the Conference Declaration.

Reaction to the country presentations focused primarily on two issues: the ENHR Strategy and its future facilitation and coordination.

1 The ENHR Strategy

While there was overall support for the ENHR Strategy and the initiatives taken by countries to apply it, important questions arose.

1.1 Inclusiveness and the Three Constituencies

- Are they the correct ones?
- Should other groups be added?
- Cannot researchers, policy analysts and decision makers identify national health problems and set health research priorities using epidemiological and other information about a country's health status and services?
- How should the representatives of the various groups included in the ENHR process be chosen?

Response:

Inclusiveness is a fundamental tenet of the ENHR Strategy and researchers, decision makers and representatives of the people are the core of any ENHR process. Thus representatives of each group must be included. In addition to this core, other groups may also be represented in a national initiative, if a country so desires.

Representatives of the people are crucial to the process but they are the most difficult to bring into an effective working partnership. However, without this "grass-roots" participation the ENHR process becomes a "top-down" endeavor within a country.

Each country decides how the representatives of each constituency are chosen. This can be complex and take time, but the time and efforts are well spent if the result is a true working partnership. And it usually is.

1.2 Priority Setting Using the ENHR Process

- What are the criteria for priority setting?
- How are the criteria applied?
- How can priorities be set when epidemiological and health services data are not available?

Response:

Problems are identified and priorities are established on a national and/or sub-national basis through continuous consultations amongst the constituencies. Various methodologies are used such as analysis of epidemiological data, focus group discussions, search conferencing etc. Countries use the quantative and qualitative information available to them. While most countries are aware of criteria such as burden of disease, mortality and morbidity, incidence, prevalence, impact on quality of life, cost and effectiveness of interventions, opportunity costs, short-, medium- and long-term effects etc., and wish to have more accurate information and analysis available, they use the best information they have. Obtaining better information and using it, is part of the ENHR strategy.

Most countries, especially those with less developed research structures, indicate that capacity building to gather and analyze health and health related information is of very high priority. Research capacity strengthening in general but particularly in epidemiology, health policy analyses, health economics and the social sciences related to health are included in the highest priority group for training.

Country plans and programs are not static. As progress is made and better data and analyses become available plans and programs will be modified. Through the ENHR process these analyses and their interpretation will be available to all three constituencies and decisions on priorities will emerge from deliberations together. Valid information on health status, services and costs and the capacity to generate, analyze and use the information, are urgent needs in most developing countries and usually one of the earliest steps in the ENHR process.

Finally, priorities are always set. If not by the country and the ENHR process then by others, usually from outside the country.

1.3 Institutionalization of ENHR

- How should this be done?

- How will the ENHR group or mechanism work with other national health research initiatives and members of international health research programmes and networks within a country?

Response:

The institutionalization of ENHR is decided by the country. Most countries agree that the use of existing institutions or mechanisms, e.g., National Science or Research Councils, is preferable to the creation of new organizations. However, the choice is up to the country. There is general agreement that without institutionalization the ENHR process will not take root. A group and an institution must accept formal responsibility for the process. The group must include representatives of the three constituencies and have a formal institutional link to an agreed upon Ministry, NGO or academic center.

Existing national researchers and groups are a national resource for ENHR and a crucial component of the ENHR Strategy. All are invited and encouraged to participate in the process. National units of international networks also are key resources for the application of the ENHR Strategy. Indeed, these units frequently lead the national process. A country's ENHR initiative frequently

catalyses internal networking and collaboration amongst national researchers of different disciplines, national institutions and units of international research programs.

1.4 Developed Countries: their researchers and institutions

- What is their role in a developing country's ENHR endeavor?

Response:

The ENHR Strategy is not limited to developing countries. Today the Strategy is as necessary for the developed as for the developing countries. The developing countries hope that all countries will wish to share their ENHR experiences and to collaborate and develop partnerships with institutions and researchers from other countries. Such partnerships and the terms of collaboration will be established by the country which is grappling with a specific health problem and wishes assistance. Partnership terms will not be imposed by outside institutions even though they may have funds to offer.

The ENHR Strategy includes two basic components, country-specific research and global research. The Strategy begins with the user of the health system and services, the people. This grass roots or "bottom-up" approach is critical to its success. Regional and global health research agendas will evolve from national health problems and research plans evolved through the ENHR process, and from the gaps in knowledge and research opportunities identified through the sharing of experiences amongst countries. Methods for international collaboration and partnerships will be developed to carry out the research and solve the problems included in the global research agenda.

The WHO "Special Programs" are one successful mechanism for international collaboration in health research and undoubtedly others will evolve as the global health research agenda emerges from the needs and opportunities expressed by countries. The new mechanisms and programs will work with a clear understanding of their potential impact upon the health and quality of life in both the north and the south. New mechanisms and partnerships in financing of research also will be developed through this approach.

1.5 International Health Research Programs and country based international networks

- Will country institutions involved in the ENHR Strategy be able and willing to join such networks?

- Who will decide if a national institution will join such networks?

Response:

Whenever necessary and possible, national institutions will participate in international health research programs and networks. This is part of the ENHR Strategy. The national units of international networks are an important resource for carrying out a country's ENHR plan and participation in international research programs strengthens national research capacities.

Frequently, the priorities of international networks and research programs complement national needs and priorities. Therefore, collaboration will benefit both. If the priorities of an international health research program are not those of, or do not complement those of a country, national institutions may be discouraged from joining the network. The mechanism of deciding is determined by each country.

1.6 Choice of Research area or subject

- Will researchers be able to accept outside funds for research which is not a national priority?

- Will national researchers be able to work on issues of interest to them or must they work on issues within the ENHR plan?

Response:

A country's researchers and research institutions are a national resource and most countries believe that health researchers should devote a significant amount of their time to finding solutions to the priority health problems of their country. Priority health problems may relate to the short, medium or long- term, and each country must decide upon the "mix" and spectrum of research it deems necessary. This "mix" includes research on global health problems and may include research of interest only to a research scientist. A country's research "mix" is determined by the country.

Research institutions and scientists totally supported by "private" funds, eg., pharmaceutical companies will not necessarily work on ENHR issues. However, they invariably have plans which often relate to the needs of their country. The terms of foreign ownership of "health industries" are usually established by a country's policies in respect to foreign ownership.

1.7 The present status of ENHR plans

- Why do most country's ENHR plans focus upon short-term problems and needs?

Response:

Prof. Gelia Castillo, Deputy Chair of the Commission and a member of the Task Force told the conference participants:- *"ENHR is a long-term endeavour to enable a country, its researchers and its people to deal with their health problems. The enabling process has just begun, and countries must establish a mechanism and begin to apply the Strategy. Inevitably, when they do, they decide to tackle the immediate problems first. This is normal. Longer-term problems will be faced in due course. Give the process a chance!"* The countries agreed with Prof. Castillo's statement.

2 The Future of ENHR

2.1 A future mechanism

- Is a facilitation and coordination mechanism necessary?
- Will it be cost effective?
- Will such a mechanism duplicate existing ones?

Response:

The countries were unanimous in their belief that a mechanism to facilitate the application of the Strategy will be crucial over the next 5-10 years. Its purpose will be to:

- "broker" the acquisition of research funds and other resources for countries;
- establish and maintain communication amongst countries;
- coordinate the network of countries using the Strategy;
- enable them to share their experiences and look after their common interests; and

- assist countries with their ENHR process when requested and provide "seed" funding for planning and analysis.

The mechanism will be cost effective even if only the presently involved eighteen countries apply the Strategy. A mechanism managed by, and operated for the countries, enabling them to carry out their own essential health research programs does not exist. Thus, there will be no duplication.

2.2 The role of the World Health Organization

- What is the present and future role of WHO in respect to the ENHR Strategy?

Response:

Dr. J.P. Jardel, Assistant Director General and the head of the WHO Delegation, stated that WHO Programmes worked with the Task Force in a number of countries. WHO did not consider the proposed mechanism as competitive to WHO. The Organization welcomes any initiative aimed at improving the health and living conditions of the people of the world.

Health Systems Research is of highest priority to WHO and the WHO Health Systems Research Program had worked closely with the Task Force both in Geneva and in countries applying the ENHR Strategy. However, WHO was not convinced that a new mechanism was necessary and would not be able to participate in the establishment or management of such a mechanism. However, if the conference participants decided that there was a need for a new mechanism, WHO would collaborate with it as it had done with the Task Force.

2.3 The character of a future Facilitating Mechanism

- If the countries believe a facilitating and coordinating mechanism is crucial for the future of ENHR, what type of mechanism should be established, and where should the headquarters and secretariat be located?

Response:

Dr. Rolf Korte, Head of Division, Deutsche Gesellschaft für Technische, Zusammenarbeit (GTZ), Germany presented the views and recommendations of the Task Force and its Sub-Committee. Dr. Korte's presentation is summarized below.

To develop proposals for a future "Mechanism" the Task Force established a special **Sub-Committee on Future Mechanism to Support and Monitor ENHR and Research on Global Health Problems**. Dr. Isao Arita, Prof. David Bell, Prof. S. Bergström, Dr. J. Cook, Dr. John Evans, Dr. Lennart Freij, Dr. R. Korte (chair), Prof. V. Ramalingaswami were members Dr. Richard Wilson was the secretary of the Sub-Committee and Dr. C-H. Vigne was consulted extensively on legal aspects.

The work of the Sub-Committee was guided by the following terms of reference:

- Take note of the existing mechanisms to support and monitor national and international research endeavors and their relevance to ENHR.

- Consult with national and international bodies and agencies supporting research.

- Consider the unique aim and focus of ENHR, and develop a series of options for the support and monitoring of ENHR at national, regional and global levels. These options should take into consideration the costs associated with both the implementation and long-term operation. These costs should be realistic in relation to available national and international funds.

The Sub-Committee maintained close contact with UN and international and national agencies as well as ENHR country representatives, to inform them of the options under consideration and to invite their comments. Agencies and countries were requested to come forward with recommendations. Particularly close contact was maintained throughout the process with WHO which was considered as a natural partner.

More than 20 mechanisms for health research support were analyzed as potential means to support the ENHR Initiative. Among these were the WHO Special Programme on Research and Training in Tropical Diseases, the Special Program of Research Development and Research Training in Human Reproduction, the Diarrhoeal Diseases Control Programme and the Acute Respiratory Diseases Control Programme. Mechanisms such as the International Agricultural Research Centers (CGIAR) and the Council for International Organizations of Medical Sciences (CIOMS) were also examined, to name just a few. The pros and cons of different organizational and management structures and modes of operation were carefully analyzed.

Preliminary recommendations were presented to the Task Force in February 1992[5] and extensively discussed by the members. The views of 16 countries participating in ENHR initiatives were obtained at the Kampala Conference in April of the same year. The Sub-Committee presented its report to the Task Force in June 1992. On the basis of the report, the following recommendations were put forward by the Task Force.

In achieving the long-term objectives of ENHR, there are important roles for individual countries developing their own research policy and program; for donors to support research, capacity strengthening and networking; and for the UN System in advocacy and promotion, including the provision of an operational umbrella for a facilitating mechanism. Although ENHR is primarily country-specific, there also is a need to foster international collaboration and to establish international health research initiatives. Thus the Task Force recommended the creation of an international mechanism and Secretariat which should:

- be the international focal point;
- be in the service of countries;
- facilitate national, regional and inter-regional activities (especially networking) as well as the sharing of information;
- broker national financial and other support for countries if requested to do so;
- act as the Secretariat to a Council or whatever international policy guiding body was established; and
- be autonomous, independent, non bureaucratic, flexible and be able to react rapidly.

The location of the Secretariat was discussed extensively, and criteria for the choice were developed. The location should provide for effective function, easy access, good communication and be free from national interference or bureaucracy. Geneva, with its proximity to UNDP and WHO, was considered a potential candidate.

The preferred mechanism was an NGO under a UN umbrella, with UN-agencies, particularly WHO and UNDP as members of a group of sponsors. A small Secretariat should operate the mechanism guided by a 12-20 member Board. The possibility of a unique, experimental program within WHO was also considered, taking note that such a program must have a specific identity,

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[5] *Report on Future Mechanisms*, Task Force on Health Research for Development, June 1992.

financial and operational independence and great flexibility in management. A five year period of initial operation, with an appropriate evaluation mechanism, was considered highly desirable. Statutes were drafted along these lines to be presented to the Conference.

Some points were felt to be of special interest. Unlike the International Agricultural Research Centers the mechanism aims to use existing resources, networking them so that they may complement other national and international networks. The Board, the countries and organizations jointly form the Council which is designed to make optimal use of financial resources. It is not intended to create a new bureaucracy, but to establish a modest, flexible mechanism that will react to the demands of countries and facilitate communication and exchange of information amongst countries in the south and developed countries, donors and international organizations. Finally, it should be stressed that such a mechanism would aim to become self-financing within five years of its establishment. The future of this unique, remarkable and promising initiative now lies in the hands of the conference participants.

The Conference participants agreed that a mechanism guided by a board with the goals and functions as outlined by Dr. Korte and described in the draft Statutes as modified by the conference participants, should be established.

The revised version of the draft Statutes represent basic principles for statutes and operating procedures of the proposed facilitating mechanism. The definitive Statutes, operating procedures and financial regulations would be drawn up in keeping with the laws of the country where the mechanism will be located.

The type and location of the new organization and its secretariat generated extensive debate. Some participants preferred three or four small secretariats located in various regions of the South. The majority expressed the view that a single, small secretariat located in Geneva, within a United Nations Organization, would be most effective. The possibility for small regional Secretariats in the South in association with the Geneva group would remain under consideration. The Countries applying the ENHR Strategy indicated that a central, Geneva based Secretariat would be the most effective mechanism to meet their needs.

The Conference agreed to the establishment of a non-governmental organization to be located and registered in Geneva, Switzerland, and situated within the United Nations Development Programme, for an initial five year period. The participants adopted the following Declaration.

Declaration On Health Research For Development

The participants to the Second International Conference on Health Research for Development assembled in Geneva at the Palais des Nations on 8 and 9 March 1993.

Considering that research is an essential link between human aspiration and action;

Recognizing that the focus of Health Research should be national and each country should have the health research capacity to enable it to understand its own problems and enhance the impact of its resources;

Recognizing that Essential National Health Research (ENHR) defined as a comprehensive strategy for organizing and managing national research should serve as a starting point to lead countries towards better and more equitable health and to identify common Health Research problems, gaps in knowledge and needs and opportunities for regional and global collaborative health research;

Recognizing the crucial need to associate in such a common effort, researchers, policy makers and community representatives;

Having examined the Document dated 4 November 1992, submitted to the Conference outlining the proposal from the Task Force on Health Research for Development and its Management Support Group to the countries implementing the ENHR Strategy and those supporting such a Strategy, for the establishment of a mechanism for the coordination of the Strategy;

Declare to be in agreement with the establishment of such a mechanism according to the principles contained in the Document. The mechanism will be called the Council on Health Research for Development (COHRED) and will serve as a means through which countries, agencies and organizations (governmental and non-governmental), having formally expressed their interest, will work together.

The objective of COHRED will be to promote for all people, health and quality life on the basis of equity and social justice. COHRED shall promote, facilitate,

support and evaluate the ENHR Strategy and other health issues of international priority.

COHRED shall be a non-governmental institution whose membership, structure and functions will be based on the elements contained in the Document which will be adapted by the Founders of COHRED to conform to the law of the host country.

The conference participants decided that the COHRED Board, once established, should approve a Plan of Work and Budget for the new Organization. Most of the donor agencies and organizations indicated that they would be willing to consider financial support for COHRED on the basis of the Conference Declaration and the principle outlined in the draft generic statutes as revised by the conference.

The participants expressed their sincere thanks to Professor Demisie Habte for his sensitivity and skill in chairing the Conference.

The way was now open for the establishment of the Council on Health Research for Development (COHRED).

From March to November 1993:

Health Research for Development had entered a third phase. The Commission had conceived the concept of ENHR, and had begun the movement. The Task Force evolved the concept and promoted and facilitated the Strategy. Eighteen countries and groups of countries began to apply ENHR, and many more considered doing so during the tenure of the Task Force.

The Commission and the Task Force were independent in action but dependent upon the financial and administrative support of agencies since neither body was a legal entity. Now, the ENHR movement had come of age. The countries and agencies had decided to create a unique, non-governmental organization situated within the United Nations System and guided by a Board comprised primarily of individuals from the countries using the ENHR Strategy. The agencies and organizations participating in the conference, without exception, had expressed support for COHRED. UNDP, IDRC and SAREC had agreed to be part of the Constituting Assembly.

- **10 MARCH** - Meeting of Constituting Assembly. The thirteen participants, (ten elected by the Task Force and its Management Support Group, from nominations submitted by the countries implementing the ENHR Strategy and three representatives from IDRC, SAREC and UNDP) adopted the Statutes and Implementing Regulations of COHRED. (Annex I)

- **10 MARCH** - First Session of the COHRED Board.

- **17 MARCH** - COHRED Registered as a non-governmental organization in Geneva, Switzerland.

- **28 JUNE** - Second Session of COHRED Board;

  - Board Members increased to seventeen. (Annex II);

  - Rules of Procedures adopted; and

  - Financial Regulations adopted.

- **28 AUGUST** - Third Session of the Board.

  - Plan of Work and Budget
  (01 April 1993 - 31 December 1997) adopted;

- External Auditors appointed;

- Sub-Committee on Policy Options established; and

- new Coordinator selected to take office on 01 January 1994.

- **NOVEMBER** - COHRED and UNDP signed two year agreement.

- **01 DECEMBER** - First meeting of Sub-Committee on Policy Options.

On 30 November 1993, COHRED consisted of 17 Board members and 21 constituent countries, agencies and organizations. The COHRED membership structure is shown in Figure 1.
Five countries had completed their ENHR plans and were organizing meetings in early 1994 to present these plans to prospective partners.
COHRED was established and thriving.

Summary Report

of the

Constituting Assembly

of

COHRED

10 March 1993

Palais des Nations, Geneva

Summary Report

The Constituting Assembly of COHRED met on 10th March 1993 at the Palais des Nations in Geneva. Thirteen participants attended (Annex 1). WHO was represented by an observer.

The meeting was opened by Dr. R. Wilson. The participants adopted the agenda (Annex 2). Dr. J. Sepulveda was elected chairman, Dr. S. Chowdhury Vice Chairperson. Dr. C. H. Vignes was designated as secretary. The secretary explained the objectives of the meeting and presented the draft statutes and the implementing regulations of COHRED. Several participants took the floor and an amendment was put forward to Article 4 of the statutes. This consisted of the replacement of the word "a" by "each" in line one. The amendment was accepted. The amended statutes and the implementing regulations were adopted (Annex 3 & 4). Dr. Richard Wilson was appointed Coordinator of COHRED.

A "procès verbal" was written (Annex 5) which together with the other four (4) annexes was deposited with Me. J. R. Christ, notary in Geneva, on 16 March 1993.

COHRED
COUNCIL ON HEALTH RESEARCH FOR DEVELOPMENT

Constituting Assembly

Palais des Nations, Geneva, 10 March 1993
Conference Room 16 at 09.00 hours

LIST OF PARTICIPANTS

1. Mr. Keith Bezanson, International Development Research Centre (IDRC)
2. Prof. Christopher Chetsanga, Zimbabwe
3. Dr. Sadia Chowdhury, Bangladesh
4. Dr. Binta Diallo, Guinea
5. Prof. Esmat Ezzat, Egypt
6. Dr. Joseph Foundohou, Benin
7. Mr. Ariel François, United Nations Development Programme (UNDP)
8. Dr. Mary Ann Lansang, Philippines
9. Prof. Raphael Owor, Uganda
10. Prof. O. Ransome-Kuti, Nigeria
11. Dr. Jaime Sepulveda, Mexico
12. Dr. S.P. Tripathy, India
13. Mr. Anders Wijkman, Swedish Agency for Research Cooperation with Developing Countries (SAREC)

Secretary

President

CB(1)/93.1
ORIGINAL: English

COHRED
COUNCIL ON HEALTH RESEARCH FOR DEVELOPMENT

Constituting Assembly

Palais des Nations, Geneva, 10 March 1993
Conference Room 16 at 09.30 hours

AGENDA

		Reference Numbers
1.	*Opening of the Session*	
2.	*Adoption of the Agenda*	*CB(1)/93.1*
3.	*Election of Officers*	
4.	*Evolution of COHRED*	*INT/CONF(2)/93.5, Annex 2* *INT/CONF(2)93.9*
5.	*Adoption of COHRED Statutes*	*CB(1)93.2*

STATUTES

6 March 1993
CB(1)/93.2
ORIGINAL: English

COHRED
COUNCIL ON HEALTH RESEARCH FOR DEVELOPMENT

SECTION I - NAME, LEGAL STATUS AND HEADQUARTERS

Article 1 In accordance with the decision taken by the Second International Conference on Health Research for Development, an association called the Council on Health Research for Development (hereinafter called COHRED) is hereby established.

Article 2 COHRED shall have legal personality and will be governed by the present statutes and, in instances not covered by them, by article 60 and following of the Swiss Civil Code.

Article 3 The headquarters shall be in Switzerland.

SECTION II - OBJECTIVES AND FUNCTIONS

Article 4 The objective of COHRED is for all the people of each country to achieve health and quality of life on the basis of equity and social justice.

Article 5 COHRED will:

a) Promote the Essential National Health Research (ENHR) Strategy, defined as a comprehensive Strategy for organizing and managing national research;

b) Facilitate the use of the Strategy by countries that wish to implement it;

c) Establish international and regional networks through which countries can share their experiences with the ENHR Strategy;

d) Analyze the global effectiveness of the Strategy and assist countries in national analyses and assessments;

e) Bring countries together to obtain information about the Strategy and share their experiences with it;

f) Identify health problems common to countries and gaps in knowledge about health which require international collaboration to resolve; and

g) Carry out special projects.

SECTION III - ORGANIZATION

Article 6 COHRED will be composed of countries, agencies and organizations which have expressed their interest in its objectives and have been accepted by the Board.

Article 7 The Board.

7.1 The supreme policy making body of COHRED shall be the Board which shall consist of all the members accepted in accordance with the Implementing Regulations.

7.2 The Board shall:

a) adopt the Programme of Work and Budget of COHRED for the forthcoming financial period;

b) adopt Implementing Regulations, Rules of Procedure and Financial Regulations as it deems appropriate;

c) approve any Special Project;

d) decide upon the size and location of the Secretariat;

e) select the Coordinator;

f) review the Reports of Progress, Financial Statements and Audit Reports thereon;

g) consider such matters relating to COHRED as may be referred to it; and

h) maintain close relations with the countries, agencies and organizations having expressed their wish to work with COHRED.

Article 8 The Coordinator

8.1 The coordinator shall be the executive organ of the Association with individual signature.

8.2 The coordinator shall be the chief of the secretariat which shall consist of the coordinator and such technical and administrative staff as may be required.

8.3 The Secretariat shall assist the coordinator and the Board in all aspects of their functions and shall be the technical and administrative organ of the coordinator and the Board.

8.4 The coordinator shall convene the Board with at least two weeks notice.

SECTION IV - FINANCE AND AUDITING

Article 9 COHRED shall be financed through contributions, grants, gifts or bequests and payments for services from any individual, body, organization or government.

Article 10 The accounts of COHRED will be subject to audit in accordance with the financial regulations. Such an audit will be carried out at least biennially.

SECTION V - FINAL PROVISIONS

Article 11 Any member of COHRED may withdraw from participation by notifying the coordinator of its intention to do so. Such a notification will take effect six months after its receipt.

Article 12 The Board might decide on the dissolution of COHRED by a two-thirds majority of its members.

Article 13 Amendments to this Statute shall come into force when adopted by the Board by a two-thirds majority of its members.

Article 14 The present Statutes have been adopted during the constituting meeting of COHRED held in Geneva on 10 March 1993.

Secretary

President

IMPLEMENTING REGULATIONS

6 March 1993
CB(1)/93.2
ORIGINAL: English

COHRED
COUNCIL ON HEALTH RESEARCH FOR DEVELOPMENT

In accordance with Article 7 of the Statutes of the COHRED, the following Implementing Regulations have been adopted:

Article 1 - The Board shall consist of 18 Members selected by the Board itself from a list of possible Members submitted by the countries, agencies and organizations (governmental or non-governmental) which have expressed to the Coordinator their wish to work with COHRED and to observe the provisions of its statutes.

Article 2 - Two-thirds of the membership of the Board shall be from country nominees.

Article 3 - The term of office of the Members of the Board will be three years, renewable once. After two consecutive terms, a period of three years must elapse before of an individual can be reconsidered for Board membership.

Article 4 - To ensure continuity, the terms of office of the initial Members of the Board will be staggered.

Article 5 - The Board may revise these regulations.

Secretary

President

PROCÈS VERBAL

DE L'ASSEMBLEE GENERALE CONSTITUTIVE

DE COHRED

Le 10 mars 1993 à Genève au Palais des Nations, sous la Présidence du Dr. J. Sepulveda s'est tenue l'Assemblée générale constitutive du conseil de la recherche en santé pour le développement (COHRED).

Le Dr. S. Chowdhury a été choisie comme Vice-Président.

Le Président a désigné le Dr. Claude-Henri Vignes aux fonctions de Secrétaire de cette Assemblée.

Treize délégations participaient à cette Assemblée dont la liste, signée par le Président et le Secrétaire, est ci-jointe.

Au cours de cette Assemblée, les Statuts de COHRED ont été adoptés ainsi que le règlement d'exécution.

Le Dr. Richard WILSON a été nommé organe exécutif.

Les Statuts ci-joints, également signés par le Président et le Secrétaire, seront déposés au rang des minutes de Me Jean-Rodolphe CHRIST, Notaire à Genève.

Fait à Genève, le 10 mars 1993

Le Secrétaire

Le Président

PJ: 2

Annex II

COHRED Board Members, July 1993

Jaime Sepúlveda, Chairperson (Mexico)
Sadia A. Chowdhury, Vice-Chairperson (Bangladesh)
Christopher J. Chetsanga (Zimbabwe)
F. Binta Tidiane Diallo (Guinea)
Esmat Ezzat (Egypt)
Joseph Foundohou (Benin)
Lennart Freij, Swedish Agency for Research
Cooperation with Developing Countries, SAREC (Sweden)
Matthias Kerker, Swiss Development Cooperation (Switzerland)
Mary Ann D. Lansang (the Philippines)
Maureen Law, International Development Research Centre, IDRC (Canada)
Raphael Owor (Uganda)
Olikoye Ransome-Kuti (Nigeria)
Patricia L. Rosenfield (U.S.A.)
Timothy Rothermel, United Nations Development Programme, UNDP (U.S.A.)
Fabio Salamanca (Nicaragua)
Charas Suwanwela (Thailand)
Sriram P. Tripathy (India)

Annex III

Task Force on Health Research for Development, 1991-1993, Members

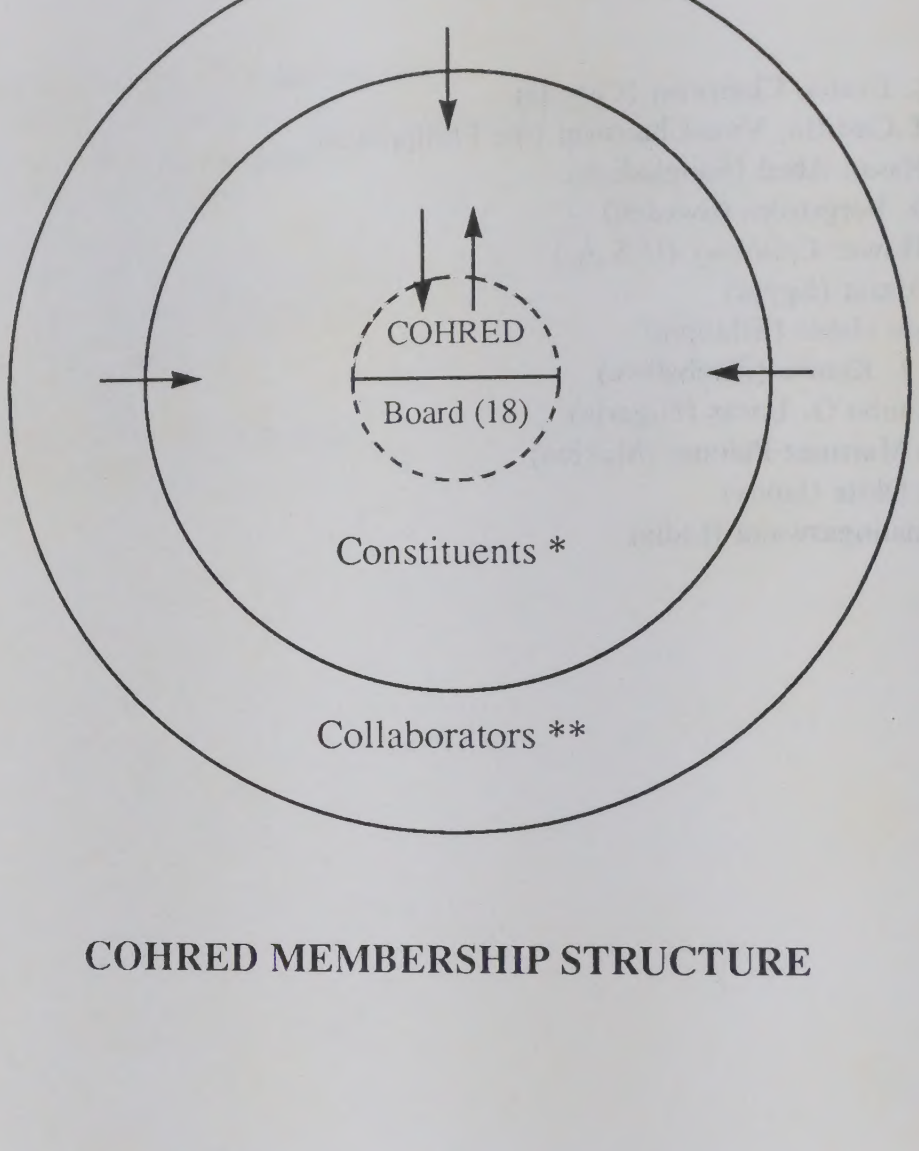
V. Ramalingaswami, Chairman (India)
Adolfo Martinez-Palomo, Vice-Chairman (Mexico)
Fazle Hasan Abed (Bangladesh)
Eusebe Alihonou (Benin)
Isao Arita (Japan)
David J. Bradley (United Kingdom)
Gelia T. Castillo (the Philippines)
Lincoln Chen (U.S.A.)
Esmat Ezzat (Egypt)
Marvellous Mholoyi (Zimbabwe)
Carlos Morel (Brazil)

Annex IV

Commission on Health Research for Development, 1987-1990, Members

John R. Evans, Chairman (Canada)
Gelia T.Castillo, Vice-Chairman (the Philippines)
Fazle Hasan Abed (Bangladesh)
Sune D. Bergström (Sweden)
Doris Howes Calloway (U.S.A.)
Esmat Ezzat (Egypt)
Demissie Habte (Ethiopia)
Walter J. Kamba (Zimbabwe)
Adetokunbo O. Lucas (Nigeria)
Adolfo Martinez-Palomo (Mexico)
Saburo Okita (Japan)
V. Ramalingaswami (India)

Figure 1



COHRED MEMBERSHIP STRUCTURE

* Countries, Agencies and Organizations accepted by the Board as comprising COHRED

** Countries, Agencies and Organizations working with COHRED but without formal constituent status

16 December 199

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